MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

Overview of Medicare's prospective payment systems

(To view an individual provider or supplier type, click on the type below)

Provider or supplier type

Ambulatory surgical centers

Dialysis services provided in outpatient facilities

Durable medical equipment

Home health care services

Hospice services

Hospital inpatient services

Laboratory services provided on an outpatient basis

Long-term care hospitals

Medicare Advantage plans

Outpatient hospital services

Physician services

Psychiatric hospital services

Rehabilitation facilities (inpatient)

Skilled nursing facility services

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Ambulatory surgical centers payment system

Since 1982, Medicare has covered surgical procedures provided in freestanding or hospital-based ambulatory surgical centers (ASCs). ASCs are distinct facilities that furnish only ambulatory surgery; the most common procedures are cataract removal and lens replacement, colonoscopy, and other eye procedures. Payments to ASCs (about $2 billion in 2003), including both program and beneficiary spending, account for less than 1 percent of total Medicare spending.

Medicare pays for surgery-related facility services provided in ASCs—such as operative nursing, recovery care, anesthetics, drugs, and other supplies—using a simple fee schedule (Medicare pays for the related physician services—surgery and anesthesia—under the physician fee schedule.) The ASC fee schedule sets payment rates for only nine procedure groups. The payment rates are adjusted to reflect geographic differences in market input prices.

Defining the care that Medicare buys

The unit of payment in the ASC payment system is the individual surgical procedure. Each of the 2,400 procedures approved for payment in an ASC is classified into one of nine payment groups.

Approved procedures generally are limited to those that are provided in hospital inpatient settings that also can be performed safely in outpatient facilities. Procedures frequently performed in physician offices are specifically excluded from ASC coverage. ASC-approved procedures generally require less than 90 minutes of operating room time and less than 4 hours of recovery room time.

Setting the payment rates

To set ASC payment rates, the Centers for Medicare & Medicaid Services (CMS) previously was required to survey a sample of ASCs every five years to collect data on their costs and charges for individual procedures. After auditing the survey data, CMS adjusted ASCs' charges to reflect costs using cost-to-charge ratios. CMS set the national payment rate for each of the nine payment groups equal to the estimated median cost of procedures in that group. To account for geographic differences in market input prices, CMS adjusts the labor portion of the rate using the hospital wage index for the ASC's location. The labor portion of the rate is 34.45 percent.[1]

ASC payment rates also are adjusted when multiple surgical procedures are performed during the same operative session. In this case, the ASC receives full payment only for the procedure with the highest payment rate; payments for the other procedures are reduced to one-half of their usual rates.

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[1]The labor-related portion of the rate was determined by calculating the average percentage of facility costs attributable to labor expenses for the 90 facilities included in the 1986 cost survey. The 1994 cost survey—which has not been used to update payment rates—showed that 37.66 percent of facility costs were related to labor expenses.

Between cost surveys, the ASC payment rates were updated annually based on the CPI-U. CMS is required to update the list of procedures performed in ASCs that are eligible for Medicare payment every two years.

The MMA contains many provisions that affect the ASC payment system. The legislation:

- Eliminates the payment update for ASC services for fiscal year 2005, changes the update cycle to a calendar year, and eliminates the updates for calendar years 2006 through 2009. Previously, CMS had implemented a 2-percent increase to ASC payment rates for fiscal year 2004. The MMA eliminated this increase for the second half of 2004, returning rates to their 2003 levels;

- Eliminates the provision that CMS survey ASCs' costs and charges every five years. It requires the General Accounting Office (GAO) to study the relative costs of services in ASCs and hospital outpatient departments and whether the outpatient prospective payment system's (PPS's) procedure groups reflect ASC procedures. Based on its study, the GAO should recommend whether to use the outpatient PPS's procedure groups and relative weights as the basis for the ASC payment system; and

- Requires the Secretary to implement a revised ASC payment system no earlier than January 2006 and no later than January 2008, taking into account the GAO's recommendations. Total payments under the new system should be equal to the total projected payments under the old system.

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Outpatient dialysis services payment system

Individuals with end-stage renal disease (ESRD)—irreversible loss of kidney function—require either dialysis or kidney transplantation to survive. In 1972, the Social Security Act extended all Medicare Part A and Part B benefits to individuals with ESRD who are entitled to receive Social Security benefits. This entitlement is nearly universal, covering 93 percent of all people with ESRD in the United States. Total Medicare spending for these beneficiaries has exceeded original spending projections—reaching about $15 billion in 2001—primarily because of unanticipated growth in the ESRD population. The 400,000 enrolled ESRD beneficiaries in 2001 accounted for about 1 percent of total Medicare enrollment, compared with only 0.1 percent of enrollment in 1974. This enrollment growth reflects population aging, increased prevalence of diabetes—a major risk factor for ESRD—and improvements in clinical knowledge and technique that have enabled successful treatment of older patients and those with coexisting illnesses who might not have been treated 30 years ago.

Because of the scarcity of kidneys available for transplantation, most people with ESRD (72 percent) receive maintenance dialysis. Medicare spending for outpatient dialysis and injectable drugs administered during dialysis (about $6.7 billion in 2001) accounts for 2 percent of total program expenditures but is a predominant share of revenues for dialysis facilities. Medicare pays dialysis facilities a predetermined payment for each dialysis treatment they furnish, using a payment system first implemented in 1983. The prospective payment—called the composite rate—is intended to cover the bundle of services, tests, drugs, and supplies routinely required for dialysis treatment and is only adjusted to account for differences in local input prices.

Even though technological advances have changed the provision of dialysis care since the composite rate was established, the Centers for Medicare & Medicaid Services (CMS) has neither modified the unit of payment nor used explicit criteria to determine which services should now be included. Consequently, the composite rate currently excludes several injectable drugs such as erythropoietin, vitamin D, and iron that have diffused widely into medical practice over the past decade; providers are paid separately for these services, and in 2001, drugs comprised about 40 percent of facilities' Medicare payments. In response to concerns about the effect of excluding drugs from the composite rate, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates several reports and changes how Medicare pays for injectable drugs and dialysis treatments.

Defining the care that Medicare buys

Medicare covers two methods of dialysis—hemodialysis and peritoneal dialysis. In hemodialysis, a patient's blood is cycled through a dialysis machine, which filters out body waste. About 90 percent of all dialysis

patients undergo hemodialysis three times per week in dialysis facilities. Peritoneal dialysis uses the membrane lining or the peritoneal cavity to filter excess waste products, which are then drained from the abdomen. Patients undergo peritoneal dialysis five to seven times per week in their homes.

The unit of payment is the dialysis treatment. The composite rate payment system differs from Medicare's other prospective payment systems because it uses only one product category to define the service bundle Medicare is buying. Although different equipment, supplies, and labor are needed for hemodialysis and peritoneal dialysis, the current system does not differentiate payment based on dialysis method.

Providers separately bill Medicare for certain injectable medications, including erythropoietin and vitamin D analogues, and laboratory tests that are not included in the composite rate bundle. The Congress has set the payment for erythropoietin at $10 per 1,000 units whether it is administered intravenously or subcutaneously in dialysis facilities or in patients' homes. Providers receive 95 percent of the average wholesale price for separately billable injectable medications other than erythropoietin administered during in-center treatments. Finally, providers furnishing laboratory services outside the composite rate bundle are paid according to the laboratory fee schedule.

Setting the payment rates

The composite rate is intended to cover all operating and capital costs that efficient providers would incur in furnishing dialysis treatment episodes in dialysis facilities or in patients' homes. The base payment rate is $131 for hospital-based facilities and $127 for freestanding facilities in 2004. Medicare caps its payments to facilities at an amount equal to three dialysis sessions per week, although home dialysis may be given more frequently.

The labor-related portion of the composite rate—40 percent—is adjusted for local market differences in input prices using a wage index created in 1987. This wage index blends 60 percent of a wage index based on 1980 Bureau of Labor Statistics hospital wage data with 40 percent of the fiscal year 1986 PPS hospital wage index. Both component wage indexes use labor markets based on 1980 definitions for metropolitan statistical areas and statewide rural areas. The blended wage index is limited by a floor and a ceiling; areas that have blended index values lower than 90 percent of the national average are raised to the 90 percent level (the wage index "floor"), while those with blended index values higher than 130 percent of the national average are lowered to the 130 percent level (the "ceiling"). Thus, the minimum payment is $121 and the maximum is $144 per dialysis treatment in 2004.

Dialysis facilities are reimbursed for bad debt that results when, after a good faith effort, they are unable to collect beneficiaries' 20 percent coinsurance amounts for composite rate services. Currently, bad debt payments are capped so that total Medicare payments do not exceed providers' costs in furnishing care.

For 2005, the MMA increases the composite rate paid to dialysis providers by 1.6 percent. In addition, the legislation restores special payment provisions for pediatric facilities providing dialysis under certain circumstances. The MMA also requires the Secretary to study and change several aspects of how Medicare pays for outpatient dialysis services, including:

- Adjusting payments to reflect patient mix, and other changes to current payments

  Beginning in 2005, the composite rate payment will be augmented by the difference between Medicare's payments and providers' acquisition costs for injectable drugs (i.e., the

"spread") and this augmented payment will be adjusted for patient case mix. In addition, facilities will be paid the acquisition cost for dialysis injectable drugs. Beginning in 2006, the case mix adjusted payments will be increased by the estimated growth in expenditures for injectable drugs and biologicals. To inform the Secretary's estimate, the OIG has reported on the acquisition cost of injectable drugs and their rate of growth in expenditures.

The Secretary may also phase-in a geographic adjustment to payments over a multi-year period, supplementing the current adjustment for differences in labor costs. In addition, for 2005-2007, the new system must result in the same aggregate level of expenditures as would have been made under the previous system.

- Designing a broader bundled payment system and conducting a demonstration

  By October 1, 2005, the Secretary is required to report on the design of a broader bundled payment system that includes injectable drugs, laboratory tests, and other items currently excluded from the outpatient dialysis bundle. The report will consider potential services to be included, methods to establish and update payment rates, and adjustments for patient mix, geography, and rural facilities.

  Based on this report, in 2006 the Secretary is required to begin a three-year demonstration of a broader payment bundle that includes all injectable drugs and laboratory tests. The demonstration stipulates that a sufficient number and mix of dialysis providers must participate. Participants will receive a 1.6 percent increase to the composite rate. An advisory panel established by the Secretary will aid in this task.

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Durable medical equipment payment system

Medical equipment needed at home to treat a beneficiary' illness or injury is covered under the durable medical equipment (DME) benefit. Medicare spent about $7 billion on DME in 2003, about 3 percent of fee-for-service program spending.

Wheelchairs and respirators are typical of the equipment Medicare pays for under this benefit. To be covered, the equipment must:

- withstand repeated use,
- primarily serve a medical purpose, and
- generally not be useful to a person without an illness or injury.

Thus, expendable supplies, such as bandages or incontinence pads, or otherwise useful equipment such as a humidifier, would not be covered under this benefit.

Medicare also covers prosthetics, orthotics, and some medications under its DME benefit. Covered prosthetics generally are artificial limbs; orthotics include orthopedic braces and some supportive garments. Medication that is necessary to the function performed by durable equipment is also covered under this benefit—for example, heparin administered in a home dialysis system, albuterol in a nebulizer, or chemotherapy drugs in an infusion pump.

The equipment Medicare buys

Medicare uses fee schedules to set prices for non-customized equipment, prosthetics and orthotics. These items are assigned to categories and to product groups within those categories. The categories are based on the nature of the item: whether or not it is inexpensive, needs frequent service, or is a rental item subject to an explicitly limited period of use. The categories are:

- inexpensive or routinely purchased equipment,
- items requiring frequent and substantial servicing,
- prosthetic and orthotic devices,
- capped rental items, and
- oxygen and oxygen equipment.

Within the categories, items are further categorized into about 2,000 product groups. Examples of product groups are high-strength lightweight wheelchairs and rental portable oxygen systems. All items within the same product group have the same payment rate.

The central issue in DME payment policy is the frequent failure of Medicare's payments to reflect current market prices. It is difficult for CMS to price DME in a way that is consistent with the market because the product definitions are too broad. While each product group has only one payment rate, the same product group can be used for many different items with varying prices in the retail market. Also, changing Medicare's payment rates in any way other than simple updating has been cumbersome.

CMS tested competitive bidding as a new method of purchasing DME in two areas between 2000 and 2002. In that demonstration, competitive bidding lowered prices for selected DME items between 17 and 22 percent. Preliminary analyses of the demonstration did not find serious quality or access issues.

Setting the payment rates

To ensure beneficiaries' access to needed DME, the prices that Medicare pays must cover efficient suppliers' costs of furnishing equipment for rental or purchase. Generally, the current fees are an average of the allowed charges from 1986 and 1987, adjusted by the CPI-U to account for inflation.

To capture geographic differences in prices for equipment, Medicare uses a separate fee schedule for each state. The state fee schedule prices are subject to a national floor and ceiling to limit the variability in prices across the country. The fees for prosthetics and orthotics are also determined state-by-state but are subject to regional limits. The applicable fee schedule is determined by the location of beneficiaries' residences rather than the location of the DME provider. All program payments are reduced by the 20 percent coinsurance paid by beneficiaries.

In addition to standard equipment, Medicare also purchases customized equipment and medications through this benefit but does not use the standard equipment fee schedules. The prices for customized equipment are determined item-by-item, by the regional carrier. Medications used in conjunction with DME are currently priced at a discount from the average wholesale price of the drug (AWP). In 2005, pursuant to the MMA, the prices for these drugs will be set at 106 percent of the average sale price (ASP). There are no state or regional variations in price of drugs that Medicare purchases through this benefit.

Over time, the inflation-adjusted prices have failed to reflect changes in medical equipment technology and other factors that have caused market retail prices to diverge from Medicare' payment rates. The Secretary has two alternatives to the inflation adjustment. One is adjusting prices by as much as 15 percent in one year for DME that is frequently purchased by other payers. To make the price adjustment, CMS would use an inherent reasonableness test based on a survey of market prices. The other alternative is freezing some prices or putting a limit on the amount of the annual increase.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) enacts several major changes to payments for DME. Based on the results of the competitive bidding demonstration, the MMA:

- Establishes a competitive bidding process for DME that will be phased-in nationwide, starting with ten metropolitan statistical areas (MSAs) in 2007 and expanding to 80 MSAs by 2009. In areas without competitive acquisition after 2009, Medicare may either apply competitive bidding payment rates from other areas or use its inherent reasonableness authority. Class III devices—those the FDA has categorized as new, unique, or new uses of a product—are exempt from the competitive bidding process;

- Freezes payments for DME from 2004 to 2008, or until competitive bidding is established. Payments for prosthetic devices, prosthetics, and orthotics will be frozen from 2004 to 2006, and updated by the CPI-U afterwards. Class III devices will receive payment updates from 2004 to 2006 equal to the CPI-U, and GAO will report in 2006 on the appropriate payment update for these products in 2007 and 2008; and

- Requires the Secretary to set payment amounts for certain products like oxygen and oxygen equipment, wheelchairs, and diabetic supplies by applying an update factor based on an OIG report on differences between Medicare and FEHBP payments for these products. Also, the Secretary is required to establish quality standards for DME and implement them through independent accreditation organizations.

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Home health care services payment system

Beneficiaries who are generally confined to their homes and need skilled care (from a nurse, physical or speech therapist) on a part-time or intermittent basis are eligible to receive certain medical services at home. Covered services are delivered by home health agencies (HHAs) in visits to beneficiaries' homes, including:

- skilled nursing care,
- physical, occupational, and speech therapy,
- medical social work, and
- home health aide services.

Beneficiaries are not required to make any copayments for these services.

About 2.4 million beneficiaries used home health care in 2002. Medicare's payments to HHAs were about $10 billion in 2003, accounting for a large share of HHAs' total revenues.

Until October 2000, HHAs were paid the lower of their average costs per visit or limits. In October 2000, CMS adopted a new prospective payment system (PPS) that pays HHAs a predetermined rate for each 60-day episode of home health care. The payment rates are based on patients' conditions and service use, and they are adjusted to reflect the level of market input prices in the geographical area where services are delivered. If fewer than 5 visits are delivered during a 60-day episode, the HHA is paid per visit by visit type, rather than by the episode payment method. Adjustments for several other special circumstances, such as high-cost outliers, can also modify the payment. Payment rates also are increased for patients in rural areas.

The primary challenge for the PPS is to set payment rates that are adequate to ensure beneficiaries' access to appropriate home care services. Setting rates for Medicare home health services has always been complicated by the lack of a clear definition of the benefit. The benefit was originally intended for short-term, post-hospital recovery care for beneficiaries who could not leave their homes, but changes to eligibility criteria have expanded the benefit. Certain beneficiaries who have no preceding hospital stay and are capable of spending significant time outside their homes are now eligible to receive covered services furnished in an unlimited number of home care episodes.

The care Medicare buys

Medicare purchases home health services in units of 60-day episodes. For each episode of care, the payment amount is intended to cover what an efficient provider would have to spend in furnishing visits, supplies, outpatient therapy, and patient assessments. The severity of a patient's condition changes the expected amount of resources—chiefly the number and type of visits—required for high-quality care. To capture differences in expected resource

use, patients receiving 5 or more visits are assigned to 1 of 80 home health resource groups (HHRGs) based on diagnosis, functional capacity, and service use.

Setting the payment rates

The HHRGs range from groups of relatively uncomplicated patients to those containing patients who have severe medical conditions, severe functional limitations, and need extensive therapy. Each HHRG has a national relative weight reflecting the average relative costliness of patients in that group compared with the average Medicare home health patient. The payment rates for HHRGs in each local market are determined by adjusting a national average base amount—the amount that would be paid for a typical home health patient residing in an average market—to reflect the input-price level in the local market and then multiplying the adjusted local amount by the relative weight for each HHRG.

The initial national average base payment amount for a typical home health episode is intended to reflect the projected amount providers would have received per episode under the previous payment system, updated for inflation. Because providers receive payments on a per-visit basis for patients who have fewer than 5 visits in 60 days, the base amount was adjusted to reflect this policy. It was also reduced by 5 percent to account for anticipated high-cost outlier payments. For fiscal year 2004, the national average payment rates for HHRGs range from $1,000 to $6,000.

To capture local market conditions, the per-episode payment rate is divided into labor and non-labor portions; the labor portion—77 percent—is adjusted by a version of the hospital wage index to account for geographic differences in the market prices for labor-related inputs to home health services. For most services provided in facilities, the location of the facility determines the local area adjustment that applies. For home health services, however, the local area adjustment is determined by the beneficiary's residence. The total payment is the sum of the adjusted labor portion and the nonlabor portion.

When a patients' episode of care involves an unusually large number or a costly mix of visits, the HHA may be eligible for an outlier payment. To be eligible, imputed episode costs must exceed the payment rate by 1.13 times the standard base payment amount (a portion of which is adjusted for local wages). Episode costs are imputed by multiplying the estimated national average per visit costs by type of visit—adjusted to reflect local input prices—by the numbers of visits by type during the episode. When these estimated costs exceed the outlier threshold, the HHA receives a payment equal to 80 percent of the difference in addition to the episode payment.

The base rate is updated annually. It is based on the projected change in the home health market basket, which measures changes in the prices of goods and services bought by home health agencies.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) lowered the update for home health payments by 0.8 percent for three years and restarted the 5 percent add-on payment for rural areas for one year. These two changes occur in the middle of fiscal year 2004 to allow the update cycle to change to a calendar year. The MMA asks MedPAC to study home health agencies' margins by their patient case mix. The law also suspends the collection of patient assessment instrument (OASIS) for non-Medicare and non-Medicaid patients.

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Hospice services payment system

The Medicare hospice benefit is specifically targeted to Medicare beneficiaries with a terminal illness. It covers a broad set of palliative services for beneficiaries whose physicians have determined that, if their illness runs a normal course, they have a life expectancy of six months or less. The vast majority of hospice care is provided in patients' homes. To elect the hospice benefit, beneficiaries must agree to forgo curative treatment for their terminal condition. Medicare continues, however, to cover items and services for conditions unrelated to their terminal illness.

CMS data show continued acceleration in use of the hospice benefit and associated spending. From 1998 to 2002, the percentage of beneficiaries using hospice before they died grew from 20 percent to 26 percent. Medicare spending on hospice has grown considerably in recent years—from $1.9 billion in 1995 to an estimated $5.9 billion in 2003. Despite this increase, it represents a relatively small portion of total Medicare spending (about 2 percent). Because most hospice patients are Medicare beneficiaries, Medicare payments are a large share of hospice revenues.

The hospice product and payment schedule

The hospice benefit covers a wide array of services, including:

- physician services,
- skilled nursing services,
- counseling (dietary, spiritual, family bereavement, and other counseling services),
- medical social services,
- drugs and biologicals for pain control and symptom management,
- physical, occupational, and speech therapy,
- home health aide and homemaker services,
- medical appliances and supplies
- short-term inpatient care
- inpatient respite care, and
- any other item or service listed in a patient's care plan as necessary for the palliation and management of the terminal illness.

Medicare makes daily (per diem) payments to hospice agencies for each day a beneficiary is enrolled in the hospice benefit. The daily payment rates represent payment in full for all costs that hospices incur in furnishing services identified in patients' care plans. Payments are made through a fee schedule with four different levels of care: routine home care, continuous home care, inpatient respite care, or general inpatient care. Patients are assigned to these categories based on their level of care. The majority of care—95 percent—is provided at the routine home care level. At each level of care, Medicare makes daily payments, regardless of the amount of services provided on any given day.

Per diem hospice payments are adjusted to account for differences in wage rates among

markets. The labor-related portion of the base payment amount—69 percent for routine and continuous home care, 54 percent and 64 percent for inpatient respite care and general inpatient care, respectively—is adjusted by the hospice wage index for the location in which care is furnished and the result is added to the nonlabor portion. The base rates are updated annually based on the hospital market basket index.

Hospice agencies have two fixed annual caps. One cap limits the number of days of inpatient care an agency may provide (to not more than 20 percent of its total patient care days). The other cap is an absolute dollar amount, based on the number of Medicare patients the agency serves. Total payments over total number of beneficiaries may not exceed $18,661 in the 2003 cap year (November 1 through October 31). The hospice caps are increased annually by the medical expenditure category of the consumer price index for all urban consumers.

Hospice payments were calculated based on information from a Medicare demonstration project completed in the early 1980s. The set of services included in the payment has not been examined or recalibrated to reflect possible changes in patterns of hospice care and associated costs.

Hospice care provisions in the MMA

The MMA includes several provisions related to hospice care. Specifically, the legislation:

- Enacts coverage for a one-time consultation for patients who have not yet elected hospice to evaluate their need for pain and symptom management and care options. For these consultations, hospices will be paid according to the physician fee schedule for an evaluation and management visit for problems of moderate severity and requiring medical decision making of low complexity;

- Allows nurse practitioners to serve as the attending physician for patients electing hospice. Nurse practitioners, however, cannot certify the terminal diagnosis that allows hospice to be covered by Medicare;

- Requires the Secretary to conduct a demonstration to test delivery of hospice care in rural areas. Under this demonstration, beneficiaries without a caregiver at home may receive hospice care in small facilities (20 or fewer beds) that may not normally provide hospice care in the community; and

- Authorizes arrangements with other hospice programs to provide core hospice services in certain extraordinary or exigent circumstances. Hospices also will be allowed to contract for highly specialized services.

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Hospital inpatient services payment system

Each year, about one of every five Medicare beneficiaries enrolled in the traditional program has one or more inpatient stays in a short-term acute care hospital.[1] They receive care in more than 4,800 facilities that contract with Medicare to provide services and agree to accept the program's predetermined payment rates as payment in full.[2] Payments for inpatient care accounted for the largest component—about 40 percent—of Medicare spending in 2004. These payments also provide the largest single source of hospitals' revenues—about 23 percent of overall revenues.

From its inception in 1966 until 1983, Medicare paid hospitals for inpatient services based on their incurred costs. This payment method gave providers little incentive to produce services efficiently. Because they were costly and relatively easy to distinguish, episodes of hospital inpatient care (stays) were the first to be converted to prospectively determined payment, beginning in fiscal year 1984. The hospital inpatient prospective payment system (PPS) is mature, but it nevertheless needs frequent adjustments to keep up with changes in technology, practice patterns, and market conditions that affect the amount and mix of resources hospitals use to furnish inpatient care.

The inpatient PPS pays hospitals predetermined per-discharge rates that are based primarily on two factors:

- the patient's condition and related treatment strategy, and
- market conditions in the facility's location.

Using information about patients' diagnoses, procedures, and age reported on hospitals' claims, Medicare assigns discharges to diagnosis related groups (DRGs), which group patients with similar clinical problems that are expected to require similar amounts of hospital resources. Each DRG has a national relative weight that reflects the expected relative costliness of inpatient treatment for a patient in that group compared with that for the average Medicare patient. Groups expected to require above-average resources have higher weights and those that require fewer resources have lower ones.

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[1]The Medicare inpatient hospital benefit covers beneficiaries for 90 days of care per illness episode, with a 60-day lifetime reserve. Illness episodes begin when beneficiaries are admitted for care and end after they have been out of the hospital or a skilled nursing facility for 60 consecutive days. In 2004, beneficiaries are liable for a deductible of $876 for the first hospital stay in an episode. Daily copayments—currently $219—are imposed beginning on the 61st day.

[2]Except for convenience items or services not covered by Medicare, providers are not permitted to charge beneficiaries more than the predetermined payment rate. Medicare pays the predetermined rate minus any beneficiary liability, such as a deductible or copayment; the provider then collects the remaining amount from the beneficiary or a supplemental insurer.

The payment rates for DRGs in each local market are determined by adjusting a national average base payment amount (the amount that would be paid for an average patient in a facility located in an average market) to reflect the input-price level in the local market, and then multiplying the adjusted local amount by the relative weight for each DRG. Payment rates also are increased for facilities that operate approved physician (resident) training programs, for those that treat a disproportionate share of low-income patients, and for other factors.

Because the inpatient PPS accounts for a large share of Medicare spending, it faces ongoing scrutiny, often leading to technical and policy changes. The inpatient PPS payment rates are intended to cover the costs that reasonably efficient providers would incur in furnishing high quality care, thereby rewarding those whose costs fall below the payment rates. However, financial performance under the inpatient PPS differs substantially among certain groups of hospitals. Some of these differences represent intended effects of policies adopted by the Congress. In other instances, they may reflect unintended results of inaccurate or inappropriate payment adjustments and failure to address factors that affect efficient providers' costs in certain circumstances. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) includes several provisions that significantly affect Medicare inpatient payments to hospitals.

Defining the hospital inpatient acute care products Medicare buys

Under the inpatient PPS, Medicare sets per-discharge payment rates for distinct types of treatment episodes represented by 516 DRGs, which are based on patients' clinical conditions and treatment strategies.[3] Clinical conditions are described by patients' discharge diagnoses, including the principal diagnosis—the main problem requiring inpatient care—and up to eight secondary diagnoses indicating other conditions that were present at admission (comorbidities) or developed during the hospital stay (complications). The treatment strategy—surgical or medical treatment—is described by the presence or absence of up to six procedures performed during the stay. Age is also occasionally used to distinguish groups of patients who are expected to use different amounts of resources.

The DRG definitions have a tree-like structure. Based on the principal diagnosis, cases are first assigned to one of 25 major diagnostic categories (MDCs), reflecting the affected organ system (such as the digestive system) or the etiology of the condition (such as burns or significant trauma). Within each MDC, cases are subdivided into those with and those without operating room or other significant procedures. Each of these broad groups is then further divided; the surgical group by type of procedure and the medical group by specific type of condition as indicated by the principal diagnosis. Finally, medical and surgical subgroups are often subdivided further to form DRGs distinguished by the presence or absence of comorbidities or complications indicated by specific secondary diagnoses.[4]

The Centers for Medicare & Medicaid Services (CMS) annually reviews the DRG definitions to ensure that they continue to include cases with clinically similar conditions requiring comparable amounts of inpatient resources. When the review shows that clinically similar cases within a DRG consume atypical quantities of resources, CMS often reassigns them to a different DRG with

[3] Although the federal DRG classification system includes 540 categories, 24 are not used for Medicare payment.

[4] These groups are sometimes divided further to form DRGs for pediatric patients (under age 17).

comparable resource use; less often, CMS creates a new DRG.[5]

In return for Medicare's predetermined payment rates, hospitals are expected to furnish a reasonably well-defined bundle of inpatient services for each DRG. Facing fixed payment rates, however, providers have financial incentives to reduce their inpatient costs by moving some normally included services to another setting—such as an outpatient department or a skilled nursing facility—and bill those services separately. To counter these financial incentives, Medicare has adopted policies that help to strengthen the boundaries of the inpatient service bundles associated with the DRGs. Thus, patients must stay overnight before their discharges qualify for payment under the inpatient PPS. Related outpatient department services that were delivered in the three days before admission are included in the payment for the inpatient stay and may not be separately billed (the 72-hour rule). Similarly, payments for services may be reduced when patients are transferred to another hospital after a stay that is more than one day shorter than the national average stay for the DRG. The same payment reductions apply for certain DRGs when patients are transferred to post-acute care facilities, such as rehabilitation or skilled nursing facilities, or discharged to receive clinically related home health care that begins within three days.

Setting the payment rates

Medicare sets separate per-discharge operating and capital payment rates, which are intended to cover the operating and capital costs that efficient facilities would be expected to incur in furnishing covered inpatient services.[6] Operating payment rates cover costs for labor and supplies; capital payment rates cover costs for depreciation, interest, rent, and property-related insurance and taxes. Medicare sets operating and capital payment rates using similar methods and factors.

The base payment amount Medicare sets one operating base payment amount (known as the standardized payment amount) representing what a hospital would be paid for operating expenses for an average Medicare patient (before any adjustments).[7] The base operating amount per discharge for fiscal year 2004 is $4,411. The MMA made permanent the use of a single operating base payment amount for all hospitals.

Capital payments have only recently been made fully prospective, having completed a 10-year phase-in during fiscal year 2001.[8] The base capital rate for discharges from any hospital for fiscal year 2004 is $414.

The diagnosis related group relative weights Medicare assigns a weight to each DRG reflecting the average relative costliness of cases in that group compared with that for the average Medicare case. The same DRG weights are used to set operating and capital payment rates. CMS recalibrates the DRG weights annually based on average

[5]For example, CMS established a new DRG when it found that tracheostomy patients were substantially more costly than others in the same DRGs.

[6]Certain costs are excluded from the inpatient PPS and paid separately, such as direct costs of operating graduate medical education programs, organ acquisition costs, and bad debts related to beneficiaries' nonpayment of their cost-sharing liabilities (deductibles and copayments).

[7]Hospitals in Puerto Rico receive a 50/50 blend of the federal base payment amount and a Puerto Rico-specific rate. The MMA changed to blend to 75/25.

[8]New hospitals are exempt from prospective payment for capital costs for two years. During this period, they are paid 85 percent of their Medicare-allowable capital costs.

standardized billed charges for all PPS cases in each DRG in the most recent Medicare bill file.[9]

Hospitals with cases treated with certain technologies receive add-on payments for new technologies. CMS evaluates applications by technology firms and others for add-on payments based on criteria of newness, clinical benefit, and cost. The MMA liberalized the criteria for new technologies to qualify for add-on payments and allowed these payments to be made without budget neutrality.

Adjustment for market conditions Medicare's base operating and capital payment rates are adjusted to reflect the expected impact on efficient providers' costs of differences in local market prices for labor and other inputs. The base operating payment is adjusted by an area wage index; in Alaska and Hawaii, a cost of living adjustment (COLA) is also applied. The area wage index is intended to measure differences in hospital wage rates among labor markets; it compares the average hourly wage for hospital workers in each metropolitan statistical area (MSA) or statewide rural area relative to the nationwide average.[10] The wage index is revised each year based on wage data reported by PPS hospitals on their annual Medicare cost reports. The COLA reflects the higher costs of supplies and other nonlabor resources in Alaska and Hawaii; it increases the nonlabor portion of PPS operating payments—38 percent of the total—for hospitals in these states by as much as 25 percent.

The wage index is applied to the labor-related portion of the standardized payment amount—62 percent of the total for fiscal year 2005—which reflects an estimate of the portion of operating costs affected by local wage rates and fringe benefits. The MMA increased payments to hospitals in low-wage areas by reducing the labor-related share from CMS's previous standard of 71 percent to 62 percent in areas with a wage index less than or equal to 1.0. Hospitals in higher-wage areas (with a wage index above 1.0) are held harmless.

The federal rate for capital payments is adjusted to reflect local market conditions using a geographic adjustment factor (which is based on the area wage index) and, for Alaska and Hawaii, the same COLA. The federal rate is increased by 3 percent for hospitals in MSAs with a population of one million or more.

Other adjustments Payment rates also may be adjusted to reflect higher costs of care in hospitals that operate approved resident training programs, revenue losses associated with treating low-income patients, and the financial burden of exceptionally high-cost cases. These adjustments are intended to preserve access to care for Medicare beneficiaries by protecting hospitals that face

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[9]Hospitals' billed charges are standardized to improve comparability. This involves adjusting charges to remove differences associated with variations in local market prices for inputs and those related to the size and intensity of hospitals' resident training activities.

[10]A hospital may request geographic reclassification to an adjacent market area for the standardized payment amount, the wage index (and capital geographic adjustment factor), or both. To qualify, a hospital must demonstrate proximity (location within 15 miles of the border of the adjacent area for urban hospitals and 35 miles for rural hospitals). It also must show that its hourly wages are above average for its market area (above 106 percent for rural hospitals and 108 percent for urban hospitals) and comparable to wages in the area to which it seeks reclassification (at least 82 percent of that area's average for rural hospitals and 84 percent for urban hospitals). The MMA permits hospitals to apply for a one-time appeal of their reclassification status, which lasts for three years, and also allows certain hospitals to qualify for a higher wage index based on county commuting patterns.

certain cost or revenue pressures.[11] Medicare also makes special payments designed to help rural hospitals, although some urban facilities also may qualify.[12] These include provisions for sole community hospitals, rural referral centers, and small Medicare-dependent hospitals. Certain rural hospitals qualify for cost-based payment as critical access hospitals (CAHs) and are no longer covered by the inpatient PPS. Eligible hospitals may qualify for capital exceptions payments if they meet project size, need and, for certain urban hospitals, excess capacity tests, or if they incur extraordinary capital expenditures in excess of $5 million.

The MMA includes several provisions to aid rural hospitals. It allows CAHs to use up to 25 beds for acute patients, an increase from the prior limit of 15 acute beds. The provision also curtails hospitals' ability to convert to critical access hospital status starting in 2006. It also creates a low-volume adjustment for rural hospitals that are more than 25 miles from another hospital. Facilities with fewer than 800 discharges from all payment sources may qualify for this payment add-on.

Medical education payments Teaching hospitals receive add-on payments to reflect the additional (indirect) costs of patient care associated with operating approved physician training programs. The size of the indirect medical education (IME) adjustment applied to DRG payments depends on the hospital's teaching intensity, as measured by the number of residents per bed. In 2004, approximately 1,100 hospitals received IME payments; nearly 95 percent of those facilities were located in urban areas, although they served Medicare beneficiaries living in both urban and rural areas. The MMA temporarily raises indirect medical education payments, with a four-year phase-down to an adjustment rate slightly below the current rate. Medicare makes payments for the direct costs of operating graduate medical education (GME) programs based on hospital-specific costs per resident in a base year. The MMA freezes per resident payment amounts for hospitals that currently have per resident amounts that are more than 140 percent of the national average.

Disproportionate share payments Hospitals that treat a disproportionate share (DSH) of low-income patients receive additional payments that are intended to partially offset their revenue losses from furnishing uncompensated care. As amended by the MMA, the DSH adjustment is based on five different formulas and depends on urban or rural location, number of acute care beds, and rural referral center status.[13] The amount of the adjustment—the add-on percentage from the applicable formula—depends on the hospital's low-income patient share. A hospital's low-income patient share is the sum of the proportion of its Medicare inpatient days furnished to patients eligible for Supplemental Security Income benefits and the proportion of its total acute inpatient days furnished to Medicaid patients. No DSH payments are made unless a hospital's low-income patient share exceeds 15 percent.

The MMA increased the maximum disproportionate share add-on from 5.25 percent to 12 percent of base inpatient payments for most rural hospitals and small urban hospitals.

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[11] Medicare also reimburses acute-care hospitals for bad debts resulting from beneficiaries' nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts. The Balanced Budget Act of 1997 reduced these payments, but BIPA added some back. As a result, Medicare paid 70 percent of allowable bad debts in fiscal year 2004.

[12] These special payment provisions are discussed in greater detail in MedPAC's June 2001 Report to the Congress.

[13] A special adjustment rate applies to hospitals that receive at least 30 percent of their inpatient revenue from state and local government subsidies.

Outlier payments In general, hospitals are expected to offset losses on some cases (in which costs exceed the payment rate) with gains on others (in which costs are below payments). Some cases, however, are extraordinarily costly, producing losses that may be too large to offset. Hospitals facing fixed payment rates have strong financial incentives to avoid patients who may be likely to require extraordinary care. To promote access to high-quality inpatient care for seriously ill beneficiaries, Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital DRG payments.

Outlier cases are identified by comparing their costs to a DRG-specific threshold that is the sum of the hospital's DRG payment for the case (both operating and capital), any IME and DSH payments, and a fixed loss amount. For instance, in 2004 the threshold is set at the hospital's DRG payment plus any IME, DSH, and new technology add-on payments plus $31,000—the national fixed loss amount—adjusted to reflect input price levels in the hospital's local market. Medicare pays 80 percent of hospitals' costs above their fixed loss thresholds (90 percent for burn cases). Costs for individual cases are estimated by reducing the hospital's covered charges for the case by its overall Medicare cost to charge ratio from its most recent tentatively settled annual cost report. IME and DSH adjustments are not applied to outlier payments. Outlier payments were funded in 2004 by offsetting reductions in the operating base payment amounts (5.1 percent) and the capital federal rate (4.8 percent).

Transfer policy Medicare reduces DRG payments when the patient is transferred to another PPS hospital, or in some instances to a post-acute care setting. When a patient is transferred to another PPS hospital, the transferring facility is paid a per diem amount for each day before the transfer occurs, up to a maximum of the full DRG payment.[14] The hospital receiving a transferred patient is paid according to the appropriate DRG, which may or may not be the same as the DRG assigned in the preceding hospital stay, as if the case had not been transferred.[15] Discharges in 29 DRGs are treated as transfers if patients are sent to a long-term care hospital or a rehabilitation, psychiatric, or skilled nursing facility, or they receive clinically related home health care.

Payment updates Both the operating and capital payment rates are updated annually. The Congress sets the operating update in law; the Secretary determines the annual capital update. The MMA increases inpatient payments by the projected increase in the market basket index in fiscal years 2005 through 2007. However, payments to hospitals that fail to provide data on specified quality indicators will be reduced by 0.4 percent.

[14]The per diem rate is the hospital's DRG payment rate divided by the national average length of stay for the same DRG. Generally, hospitals receive twice the per diem rate for the first day and the per diem rate for each additional day up to the full DRG rate. Hospitals may also receive outlier payments calculated using a loss threshold prorated to reflect the length of stay.

[15]If the patient is discharged to another PPS hospital, the transfer payment rules again apply.

MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

Outpatient laboratory services payment system

Clinical laboratory tests help physicians diagnose, treat, and monitor patients' illnesses and conditions. Beneficiaries may receive tests during a hospital stay or a visit to a physician's office or outpatient department. Medicare pays hospitals for tests furnished during a hospital stay as part of the bundled inpatient payment. In contrast, Medicare pays the labs directly based on a fee schedule for tests performed in an outpatient setting. Three main types of labs serve ambulatory patients: hospital-based labs; independent labs, which usually serve a region; and physician office labs, which generally perform only relatively simple tests. Laboratory payments account for about 2 percent of total Medicare spending. Medicare payments account for about 30 percent of laboratories' revenues.

Medicare uses a simple prospective payment system (PPS), a fee schedule, established in 1984. Payment rates were initially set separately for more than 1,100 tests in each carrier's geographic market, based on what local labs charged in 1983; since then, the rates have been updated periodically for inflation. PPS payment rates are also limited by national service-specific maximums that affect almost all lab claims.

Defining the product Medicare buys

Medicare sets payment rates for more than 1,100 Healthcare Common Procedure Coding System (HCPCS) codes used in billing for laboratory services. Although in theory there is a separate code for each service, in practice a single HCPCS code may identify more than one testing method for a given substance or more than one substance analyzed by a single method. Panel tests, which are tests commonly ordered together, have their own HCPCS codes as well.

Setting the payment rates

The fee schedule payment rates are the total payment laboratories will receive for their services; beneficiary copayments are not required. The Centers for Medicare & Medicaid Services (CMS) assigns payment amounts for all lab HCPCS codes in each carrier market based upon 1983 charges from the laboratories in that market. Medicare payments were set at the 60th percentile of prevailing charges for freestanding laboratories and the 62nd percentile for hospital-based laboratories in each area. In 1987, fees for outpatient services in hospital laboratories, other than those performed in sole community hospitals, were reduced to the 60th percentile of prevailing charges. Fee schedule amounts differ from carrier to carrier in some instances, but no separate geographic adjustment is provided.

Beginning in 1986, the Congress established upper limits on laboratory payment rates, called national limitation amounts (NLAs). NLAs are based on the median of all carrier rates for each test. The NLAs have been repeatedly reduced and currently are set at 74 percent of the median of all local fee schedule amounts for each procedure. Because so many

of the carrier payment rates are constrained by the NLAs, most lab services are paid the same national rate.

When newly developed tests are used by laboratories, CMS either assigns payment rates based on their similarity to existing tests or requires carriers to independently set the rates for the first year of use. Carriers must research and set their own payment amounts: They may obtain cost data from manufacturers, payment data from other carriers, or perform their own analyses.

There are some exceptions to the fee schedule for clinical laboratory tests furnished on an outpatient basis. For example, critical access hospitals are paid for laboratory tests on a reasonable cost basis, instead of by the fee schedule. The MMA introduces an additional exception to the fee schedule. The legislation allows hospitals with fewer than 50 beds in a qualified rural areas—those with population densities in the lowest quartile of all rural areas—to be paid based on reasonable costs for outpatient clinical laboratory tests. This exception will apply to cost reporting periods between July 2004 and July 2006. In addition, the MMA requires the Secretary to conduct a demonstration on using competitive acquisition for clinical laboratory test by the end of 2005.

MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

Long-term care hospitals payment system

Patients with clinically complex problems, such as multiple acute or chronic conditions, may need hospital care for relatively extended periods of time. Some are admitted to long-term care hospitals (LTCHs). Other patients—especially in the many markets without these hospitals—may be cared for in acute care hospitals or skilled nursing facilities (SNFs). Payments to LTCHs (about $2.6 billion in 2003) represent only a small part of total Medicare spending (less than 1 percent); however, Medicare accounts for a substantial proportion of these hospitals' revenues.

Beginning in October 2002, LTCHs are paid predetermined per-discharge rates based primarily on the patient's diagnosis and market conditions in the facility's location.[1] Before then, LTCHs were paid for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, subject to an annually adjusted facility-specific limit.

Discharges are assigned to case-mix categories containing patients with similar clinical problems that are expected to require similar amounts of resources. Each case-mix category has a national relative weight reflecting the expected relative costliness of treatment for a patient in that category compared with that for the average Medicare LTCH patient. The payment rates for case-mix categories in each local market are determined by adjusting a national average base payment amount to reflect the input-price level in the local market, and then multiplying the adjusted local amount by the relative weight for each case-mix group. Payment rates also are increased for hospitals located in Alaska and Hawaii and for cases that are extraordinarily costly. Payment rates are adjusted for patients that have very short stays and for those who are transferred to an acute care hospital, an inpatient rehabilitation facility (IRF), or a skilled nursing facility (SNF) for a specified amount of time, followed by readmission to the same LTCH.

LTCHs are not distributed evenly through the nation. Policy makers have questioned how beneficiaries who need this type of care are treated in areas of the country where there are no LTCHs. MedPAC studies have found that acute hospitals and skilled nursing facilities are the principal alternatives to LTCHs.

Defining the long-term care hospital products Medicare buys

Under the prospective payments system (PPS) for care in LTCHs, Medicare sets payment rates for 518 types of treatment episodes. These episodes are called long-term care

[1] LTCHs began receiving payments under the new PPS at the beginning of their 2003 cost reporting periods. During a five-year transition period, they are paid a blend of the PPS rate and their updated facility-specific rate. For example, in the first year of PPS, payments will be made up of 20 percent PPS rates and 80 percent facility-specific rates; in the second year, payments will be made up of 40 percent PPS rates and 60 percent facility-specific rates. LTCHs also can choose to be paid at 100 percent of the PPS rate; CMS estimates that 93 percent of LTCHs have chosen this option

diagnosis related groups (LTC-DRGs) and are the same groups of patients used for the acute care hospital PPS. Patients are assigned to these treatment categories based on the discharge diagnosis, including the principal diagnosis, up to eight secondary diagnoses, up to six procedures performed, age, sex, and discharge status of the patient. LTCHs may receive partial payments for patients who do not receive a full course of treatment.

Setting the payment rates

The PPS payment rates are intended to cover all operating and capital costs that efficient LTCHs would be expected to incur in furnishing covered acute long-term care services. The initial payment level (base rate) for a typical discharge is $36,833.69 for the 2005 rate year. Because providers will receive additional payments under the PPS for extraordinarily costly patients (high-cost outliers), the base rate has been reduced 8 percent to maintain the same expected total spending.

The base rate is adjusted to account for differences in input prices among markets. This adjustment is being phased in over five years. The labor-related portion of the base payment amount—73 percent—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion.[2] For LTCHs in Alaska and Hawaii, the nonlabor portion is adjusted by a cost of living adjustment (COLA) and added to the labor-related portion.[3] The adjusted rate for each market is multiplied by the relative weights for all LTC-DRGs to create local PPS payment rates.

Relative weights for the LTC-DRGs differ from the acute care hospital diagnosis-related group (DRG) weights. Medicare assigns a weight to each LTC-DRG reflecting the average relative costliness of cases in the group compared with that for the average Medicare case. LTC-DRGs with less than 25 cases in 2001 have been grouped into five categories based on their average charges; relative weights for these five case-mix groups have been determined based on the average charges for the LTC-DRGs in each of these five groups.

LTCHs are paid adjusted PPS rates for patients who do not receive a full course of treatment. Short-stay outliers are defined as cases with a length of stay up to and including five-sixths of the geometric average length of stay for the LTC-DRG. LTCHs are paid for short-stay outliers the least of:

- 120 percent of the cost of the case,
- 120 percent of the LTC-DRG specific per diem amount multiplied by the length of stay for that case, or
- the full LTC-DRG payment.

LTCHs are paid adjusted PPS rates for patients who are extraordinarily costly. High-cost outlier cases are identified by comparing their costs to a LTC-DRG-specific threshold that reflects the DRG payment for the case plus a fixed loss amount. For example, in 2005 the threshold is set at the LTC-DRG payment plus $17,864—the national fixed loss amount—adjusted to reflect the input price levels in the local market. Medicare pays 80 percent of the LTCHs' costs above their fixed loss thresholds. High-cost outlier payments are funded by offsetting reductions in the base payment amount (8 percent).

LTCHs receive one payment for patients who are transferred from the LTCH to another

[2]The wage index used to adjust LTCH payments is calculated from wage data reported by acute care hospitals without the effects of geographic reclassification.

[3]The COLA reflects the higher costs of supplies and other nonlabor resources in Alaska and Hawaii; and increases the nonlabor portion of the payment by as much as 25 percent.

facility for a specified period of time and return to the LTCH—so-called "interrupted stays". Interrupted stays are defined as those cases in which a LTCH patient is discharged to an inpatient acute care hospital, an IRF, or a SNF for a specified period followed by readmission to the same LTCH. The specified period of time for an interrupted stay when the patient is discharged to an acute care hospital is 9 days, to an IRF is 27 days, and to a SNF is 45 days. In addition, any LTCH discharge readmitted within three days is considered an interrupted stay.

Finally, Medicare has established two 5-percent thresholds to discourage transfers between LTCHs and other providers followed by readmissions to the LTCH when the LTCH and any of the other providers are located in the same facility or on the same campus (co-located). Medicare's concern about such transfers is that they may occur as a result of financial instead of clinical considerations. Within a cost reporting period, Medicare treats transfers to co-located acute care hospitals followed by readmissions to the same LTCHs above a threshold of 5 percent of all cases as if they were one LTCH discharge for payment purposes. Until the threshold is exceeded, Medicare treats each case as a discharge. A separate 5-percent threshold applies to cases transferred to co-located SNFs, IRFs, and psychiatric facilities.

Annual update and policy changes

On May 7, 2004, CMS published a final rule to update prospective payment system (PPS) rates for long-term care hospitals (LTCHs) for the rate year beginning July 1, 2004 and ending June 30, 2005. The rule:

- Updates LTCH payment rates by 3.1 percent, increasing the base rate for 2005 to $36,833.69.

- Expands interrupted stays to include readmissions to the LTCH within 3 days of discharge. LTCHs will also become responsible for costs of any treatment provided patients during those days.

- Requires LTCHS to have an average length of stay greater than 25 days for Medicare patients. The rule changes the way CMS counts days for patients whose stays continue after the end of a LTCH's cost reporting period, by counting all days of a patient's stay in the cost reporting period in which the discharge from the LTCH occurred.

- Reduces all rates by 0.5 percent to maintain budget neutrality, and

- Clarifies language that specifies that satellite facilities and remote locations reorganizing to independently become LTCHs must independently meet the average length of stay requirement before they can become Medicare LTCHs. These facilities are paid under the acute hospital PPS until they qualify. CMS also institutes an exception for satellites and remote locations that were required to separate from an LTCH because of provider-based regulations to allow them to use length of stay data from five of the previous six months prior to when they were required to separate.

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601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

Medicare Advantage plans payment system

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) establishes a new program for private plans called Medicare Advantage (MA). Much of the new program will be based on the rules and payment structure of the Medicare+Choice program, which allows Medicare beneficiaries to receive their Medicare benefits from a private plan rather than from the traditional fee-for-service (FFS) program. Under some MA plans, beneficiaries may receive additional benefits beyond those offered under traditional Medicare and may pay additional premiums. Medicare pays plans a capitated rate for the 11 percent of beneficiaries currently enrolled in Medicare+Choice, now known as local MA plans. These payments amounted to $36 billion in 2003, 14 percent of total Medicare spending.

Defining the Medicare Advantage products Medicare buys

Under the MA program, Medicare buys calendar months of insurance coverage for its beneficiaries from private plans. The coverage must include all Medicare benefits except hospice. Plans may limit enrollees' choices of providers more narrowly than under the traditional fee-for-service program. Plans may supplement Medicare benefits by reducing cost-sharing requirements, providing coverage of non-Medicare benefits, or providing a rebate of all or part of the Part B premium. To pay for these additional benefits, plans use savings in providing Medicare benefits and may charge a supplemental premium.

Setting the payment rates

Medicare payment rates for local MA plans are based on enrolled beneficiaries' characteristics and the counties in which they live. Medicare uses beneficiaries' characteristics to develop a measure of their expected relative risk for covered health spending. The payment rate for a plan enrolling a beneficiary is then calculated using the base rate for the beneficiary's county of residence, adjusted for the beneficiary's expected relative health risk. The base rate for each county is based on its historic average per capita spending in the traditional Medicare program, local levels of input prices, and the health risk characteristics of its Medicare population. In response to previous concerns that plans could not survive in areas with low payment rates (because of historically low per capita Medicare spending), the Congress set floors to raise the lowest rates.

Medicare calculates a beneficiary's relative expected cost—compared with the average expected cost for all Medicare beneficiaries—based on seven factors:

- age,
- sex,
- whether the beneficiary has end-stage renal disease,
- whether the beneficiary is also covered by Medicaid,
- whether the beneficiary is institutionalized,
- whether the beneficiary is currently covered as an active worker under an employer-sponsored plan, and

- a health risk score based on diagnoses recorded for the beneficiary during the preceding year.

The county-level rates are determined administratively, based on statutory formulas. The 2004 rate for a county is the highest of four values, the last of which was added by the MMA:

- a floor rate updated by the per-capita national average growth in traditional Medicare spending (6.3 percent), equal to $614 for counties in metropolitan areas with 250,000 or more people, or $555 for all other counties in 2004;
- the county's 2003 rate increased by the national average growth percentage;
- a 50/50 blend of an input price-adjusted national average rate and an updated historical rate based on the county's 1997 payment rate. (All blended rates are adjusted by a budget neutrality factor that constrains national payments, however, the MMA fully funds the blend for 2004); or
- 100 percent of the county FFS spending rate, calculated by excluding spending related to direct medical education (but including indirect medical education) and including spending by the Veterans Administration and the Department of Defense for Medicare benefits provided to their recipients. The latter adjustment has not been implemented yet.

The MMA sets the update for all local MA rates after 2004 to the maximum of the national per capita growth rate or a minimum 2 percent update. The MMA also requires county FFS rates to be recalculated no less frequently than every three years and each county rate will be the maximum of its updated MA rate or its FFS rate.

Additional changes to the Medicare Advantage program

Changes related to local and regional PPOs operating under Medicare Advantage include:

- Implementing a two-year moratorium on the creation of new local PPOs, beginning in 2006;
- Requiring that regional plans offer a single part A and B deductible and a catastrophic out-of-pocket cap. Payments are not increased to account for these requirements, and the deductible and cap values are not specified;
- Setting the federal government's payment benchmark at the local MA rate for plans operating on a county basis, and at the weighted average of local rates for regional plans;
- Requiring local and regional plans to submit bids for covering a beneficiary. If a plan bids below its benchmark, 75 percent of the savings will be rebated to beneficiaries to lower their premiums for Part B, Part D, or supplemental benefits. The government will keep the remaining 25 percent. If a plan bids above the benchmark, enrollees will pay all of the difference; and
- Establishing that regional plans will operate under the same rules as local plans, except that:
- Private plan bids would affect the regional benchmark in proportion to their national market share;
- Plans' benefit risk would be limited by risk corridors operating in 2006 and 2007. There would be no risk sharing within 3 percent of a target that is based on their bid, with risk shared 50/50 between plus or minus 3 percent and 8 percent of target. Medicare assumes 90 percent of additional costs (or savings) beyond more (or less) than 8 percent above the target; and
- A stabilization fund will provide additional incentives for plan entry and retention.
- Calling for a demonstration program in 2010 in which regional MA plans would compete with FFS Medicare in certain metropolitan statistical areas.

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601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

Outpatient hospital services payment system

Medicare beneficiaries receive a wide range of services in hospital outpatient departments, from injections to surgical procedures requiring general anesthesia. Spending for these services is growing rapidly, largely because of changes in technology and medical practice that have fostered new services and encouraged shifts in care from inpatient to ambulatory care settings. Outpatient hospital care accounted for about 7 percent of total Medicare spending in 2001, or about $16 billion.[1]

Medicare originally paid hospitals for outpatient care based on their costs. The Balanced Budget Act (BBA) of 1997 almost completely eliminated such cost-based payment by requiring the Centers for Medicare & Medicaid Services (CMS) to develop and adopt an outpatient prospective payment system (PPS), which was implemented in August 2000.

In requiring the outpatient PPS, the Congress also reduced beneficiary copayments for outpatient hospital care. When the BBA was enacted, copayments accounted for about 50 percent of total Medicare payments to hospitals for outpatient care. Under the new payment system, beneficiaries' share of total payments will slowly decline until it reaches 20 percent. In 2003, beneficiaries paid 38 percent of total payments under the outpatient PPS.

Like the payment system for physician services, the outpatient PPS is a fee schedule. It sets payment rates for individual services based on a set of relative weights, a conversion factor, and an adjustment for geographic differences in input prices. The PPS also includes an outlier adjustment for extraordinarily high-cost services and so-called pass-through payments for certain new technologies that are used as inputs in the delivery of services.

Because of uncertainty about the effects of the new system, certain types of hospitals are at least partially protected from financial losses. Cancer and childrens' hospitals are permanently held harmless from losses; small rural hospitals are held harmless through 2005. Other hospitals that experience losses are eligible for partially offsetting payment adjustments through 2003.

Defining the outpatient hospital products that Medicare buys

Medicare pays for outpatient services based on the individual service or procedure provided, as identified by a Healthcare Common Procedure Coding System (HCPCS) code. CMS classified procedures, evaluation and

[1]Total spending on all hospital outpatient services (those covered by the outpatient PPS as well as those paid under separate fee schedules or based on costs) accounted for $21.6 billion in 2003.

management services, drugs and devices furnished in outpatient departments into about 700 ambulatory payment classifications (APCs). These APCs group items and services that are clinically similar and use comparable amounts of resources. More than 300 of the APCs identify drugs or devices used in conjunction with a procedure. In addition, some new services are assigned to certain "new technology" APCs based only on similarity of resource use. CMS chose to establish new technology APCs because some services were too new to be represented in the data used to develop the outpatient PPS. Services will remain in these APCs for two to three years while CMS collects the clinical and cost data necessary to refine and update the APC classification system. Additional services may be placed in the new technology APCs after review by CMS.

Within each APC, CMS bundles integral services and items with the primary service. For example, the bundle for a surgical procedure includes operating and recovery room services, most pharmaceuticals, anesthesia, and surgical and medical supplies. In deciding which services to bundle and which to pay separately, CMS considered comments from hospitals, hospital suppliers, and others. For example, in response to public comments, CMS separated corneal tissue acquisition, maintenance, and distribution from services requiring corneal tissue. CMS also pays separately for blood, blood products, and plasma-based and recombinant therapies.

Unlike all other services included in the outpatient PPS—for which the unit of payment is the service or procedure provided—partial hospitalizations for psychiatric services are paid on a per diem basis. These intensive outpatient psychiatric services may be provided by a hospital outpatient department or by a community mental health center, and the per diem payment rate represents the expected facility costs for a day of care.

Setting the payment rates

Payment rates in the outpatient PPS are intended to cover hospitals' operating and capital costs for the facility services they furnish; professional services (physicians' services provided to individual patients, for example) are paid separately. Outpatient payment rates are determined by multiplying the relative weight for an APC by a conversion factor. Except for the new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. Services are assigned to a new technology APC based on their expected cost. New technology APCs range from $0–$50 to $9,500–$10,000; the relative weights are set at the midpoint of these ranges.

The conversion factor translates the relative weights into dollar payment amounts. The initial conversion factor was set so that projected total payments—including beneficiaries' copayments—would equal the estimated amount that would have been spent under the old payment methods, after correcting for some anomalies in statutory formulas.

To account for geographic differences in input prices, the labor portion of the conversion factor (60 percent) is adjusted by the hospital wage index.

The outpatient PPS includes four additional payment adjustments: pass-through payments for new technology; outlier payments for high-cost services; hold-harmless payments for cancer, children's and small rural hospitals; and transitional corridor payments that help to limit hospitals' financial losses under the PPS.

In addition to the new technology APCs, the pass-through payments are a second way that the outpatient PPS accounts for new technologies. Unlike the new technology APCs, however, pass-through payments are not payments for individual services. Instead,

they are payments for certain new technology items—drugs, biologicals, and implantable devices—that are used in the delivery of services. By supplementing the payments for individual services, pass-through payments are meant to help ensure beneficiaries' access to new technologies that are not well represented in data that CMS uses to set the PPS payment rates. For drugs and biologicals, the payments are based on average wholesale prices. For devices, the payments are based on each hospital's costs (as determined by adjusting its charges using a cost-to-charge ratio). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) prevents the Secretary from using a functional equivalence standard for setting pass-through payment rates.

By law, total pass-through payments are limited to 2.0 percent of total payments under the outpatient PPS in 2004 and beyond, and the conversion factor is reduced by 2.0 percent to finance them. If CMS projects that pass-through payments will exceed this limit during a year, the agency is required to reduce all pass-through payments in that year by a uniform percentage to meet the limit. However, CMS did not maintain budget neutrality from August 2000 to April 2002.

Outlier payments are made for individual services or procedures with extraordinarily high costs, compared with the payment rates for their APC group. In 2004, outliers are defined as services with costs that exceed a threshold equal to 2.6 times the PPS payment rate. Hospitals will be reimbursed for 50 percent of the difference between the threshold and the cost of the service in 2003. Aggregate outlier payments are limited to 2 percent of total payments; outlier payments are financed by reducing the conversion factor by 2 percent.

Certain classes of hospitals, such as cancer, children's, and some rural hospitals, are held harmless from financial losses under the PPS. These hospitals are paid according to the PPS payment rates. If their PPS payments are lower than those they would have received under previous policies, however, they will receive extra payments to make up the difference. The Balanced Budget Refinement Act of 1999 (BBRA) mandated permanent hold harmless protection for cancer hospitals and for the outpatient departments of small rural hospitals (100 or fewer beds) through 2003. In addition, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) granted permanent hold harmless protection to children's hospitals. Recently, the MMA extended the protection for small rural hospitals through 2005 and provided hold-harmless payments to all sole community hospitals, regardless of size. The Secretary also will study the costs of rural and urban hospitals to determine if an adjustment is necessary. From the inception of the PPS through 2003, hospitals that did not have hold-harmless status were eligible for less generous transitional corridor payments if their payments under the PPS were less than they would have been under previous payment policy.

To smooth the way to the outpatient PPS, the Congress mandated transitional corridor payments that were allowed to lapse in 2004. The amount of these payments depended on the difference between a hospital's PPS payments and what it would have received under the previous payment policy. Corridor payments were intended to make up a high proportion of hospitals' small losses, but a declining proportion of larger losses. For example, in 2000 and 2001, corridor payments made up 80 percent of losses that were less than 10 percent of what the hospital would have received under previous policy, but only 70 percent of losses in the 10 to 20 percent range. In 2002 and 2003, the transitional corridor payments made up declining proportions of hospitals' revenue losses under the PPS.

The APC groups and their relative weights are reviewed and revised annually. The review considers changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information. CMS is required to consult with a panel of outside experts as part of this review. CMS also annually updates the conversion factor by the hospital market basket index unless the Congress stipulates otherwise.

Additional changes in the Medicare outpatient PPS

The MMA introduced several changes to how drugs are paid for under the outpatient PPS. The legislation enacted a floor under the payment rates for drugs in 2004 and 2005 that is tied to the average wholesale price (AWP) as of May 1, 2003. The floor depends on the type of drug:

- In 2004, the floor for sole source drugs, which includes all biologicals, will be 88 percent of the AWP. In 2005, the floor for these drugs will be 83 percent of the AWP;
- In 2004 and 2005, the floor for innovator multiple source drugs will be 68 percent of the AWP; and
- In 2004 and 2005, the floor for non-innovator multiple source drugs, i.e. generic drugs, will be 46 percent of the AWP.

The floor applies to separately paid drugs and biologicals, as well as all drugs and radiopharmaceuticals that were pass-through items in 2001.

The MMA also required payment for drugs to be based on average acquisition cost beginning in 2006, as determined by surveys conducted by the Government Accounting Office in 2004 and 2005 and the Secretary in subsequent years. In addition, the MMA mandated that separate APCs be established for drugs and biologicals costing at least $50 per administration in 2005 and 2006 and excluded separately paid drugs and biologicals from outlier payments. The government will study whether APCs for separately paid drugs should be adjusted to take into account overhead and related expenses.

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601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

Physician services payment system

Physician services include office visits, surgical procedures, and a broad range of other diagnostic and therapeutic services. These services are furnished in all settings, including physicians' offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Physician services are billed to Part B. Medicare payments to physicians (about $48 billion in 2003) account for about 18 percent of total spending.

The Medicare physician payment system was implemented in 1992. To make predetermined payments for physician services, Medicare uses a list of services and their payment rates, called the physician fee schedule, for more than 7,000 services. Many services have two payment rates: a higher rate for services provided in non-facility settings, such as physicians' offices, and a lower rate for those furnished in facilities, such as hospitals. Rates are lower for services furnished in facilities because physicians' practice costs are generally lower; the facilities furnish some of the services that physicians normally would supply in the office setting and are paid separately for them.

In determining payment rates for each service, CMS considers the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. The values given to these three types of resources are adjusted by variations in the input prices in different markets, and then a total is multiplied by a standard dollar amount, called the fee schedule's conversion factor, to arrive at the final payment amount. However, rates may be adjusted further based on what role the physician has in providing the service, additional geographic designations, and other factors.

Payments are updated every year according to a formula called the sustainable growth rate (SGR) system, which is intended to keep spending growth consistent with growth in the national economy.

Defining the services Medicare buys

Under the physician fee schedule, the unit of payment is the individual service, such as an office visit or a diagnostic procedure. These products, however, range from narrow services (an injection) to broader bundles of services associated with surgical procedures, which include the surgery and related pre-operative and post-operative visits. All services—surgical and non-surgical—are classified and reported to CMS according to the Healthcare Common Procedure Coding System (HCPCS), which contains codes for more than 7,000 distinct services.

Setting the payment rates

Under the fee schedule, payment rates are based on relative weights, which account for

the relative costliness of the inputs used to provide physician services: physician work, practice expenses, and PLI expenses. The relative weights for physician work are based on physicians' assessments of the relative levels of time, effort, skill, and stress associated with each service. The relative weights for practice expense are based on the expenses physicians incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff. The PLI relative weights are based on the premiums physicians pay for professional liability insurance.

In calculating payment rates, each of the three relative weights is adjusted to reflect the price level for related inputs in the local market where the service is furnished. Three geographic practice cost indexes are used for this purpose. The fee schedule payment amount is then determined by summing the adjusted weights and multiplying the total by the fee schedule conversion factor.

Payments under the physician fee schedule also may be adjusted to reflect other factors. First, payments are decreased if services are furnished by certain nonphysician practitioners. Services provided by physician assistants and nurse practitioners are paid at 85 percent of physicians' fees and nurse midwives' services are paid at 65 percent.

Second, payments are adjusted according to payment modifiers that appear on claims for payment to show whether the service provided was atypical. For example, physicians use a modifier to bill for a service when they assist in a surgery; payment for an assistant surgeon is 16 percent of the fee schedule amount for the primary surgeon. Other modifiers apply to multiple surgical procedures performed for the same patient on the same day, preoperative or postoperative management without surgical care, and bilateral surgery.

Third, under the Medicare incentive payment program, physicians receive bonus payments when they provide services in health professional shortage areas (HPSAs). These payments are intended to attract more physicians to HPSAs. The bonus increases payments to these physicians by 10 percent (excluding beneficiary coinsurance).

Fourth, payments are adjusted downward when services are furnished by physicians who are not in Medicare's participating physician and supplier program. Payment rates for services provided by non-participating physicians are 95 percent of the fee schedule payment rate.

The fee schedule's relative weights are updated at least every five years; HCPCS codes and the conversion factor are updated annually. The update of relative weights includes a review of changes in medical practice, coding changes, new data, and the addition of new services. In completing its review, CMS receives advice from a group of physicians and other professionals sponsored by the American Medical Association and physician specialty societies.

The annual updates for the conversion factor are made according to the SGR system, a formula intended to keep spending consistent with a target based on growth in the national economy. If actual spending is less than the target, the update is greater than the change in input prices for physician services. If actual spending is greater than the target, the update is less than the change in input prices.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates increases to the physician fee schedule's conversion factor of at least 1.5 percent in 2004 and 2005, preventing a negative update of -4.5 percent projected for 2004 and another negative update projected for 2005. In addition to these increases in payments, the MMA includes provisions that

will raise payments for services furnished by many fee-for-service physicians:

- A floor is established for the physician work component of the fee schedule's geographic practice cost index (GPCI). This floor will raise payments for services furnished in areas with below average physician work GPCIs, and will be in place from 2004 to 2006;

- Geographically adjusted payments for services provided in Alaska will increase to become 67 percent higher than the national average. That is, the work, practice expense, and medical malpractice GPCIs will each be increased to 1.67. This increase will be in effect in 2004 and 2005;

- Services provided by physicians in newly established scarcity areas—determined separately for primary care physicians and specialists—will receive a 5 percent bonus payment in Medicare payments. This bonus will occur from 2005 to 2007; and

- For the pre-existing 10 percent bonus payment to physicians practicing in designated HPSAs, responsibility for identifying eligibility will shift from the individual physician to the Secretary of Health and Human Services. These automatic 10 percent bonus payments will start in 2005.

A service furnished in an area that qualifies for both the scarcity area bonus and the shortage area bonus can receive both incentive bonuses above.

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Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

Psychiatric hospital services payment system

Medicare beneficiaries with mental illnesses or alcohol and drug-related problems may be treated in specialty inpatient psychiatric facilities (IPFs), either freestanding hospitals or specialized hospital-based units. These hospitals generally furnish short-term acute care. To be admitted to a specialty facility, patients generally have to be considered a risk to themselves or others.[1] Payments to psychiatric facilities (estimated to be $3.6 billion in 2003) represent only a small part of total Medicare spending (about 1 percent), but the program accounts for about 30 percent of psychiatric facilities' revenue. In 2000, about 300,000 Medicare beneficiaries had 433,000 discharges from IPFs for a psychiatric or substance abuse disorder, and about 2,000 facilities were Medicare certified.

Psychiatric facilities are paid for furnishing care to Medicare beneficiaries under cost growth limits established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); payments are based on their incurred average operating costs per discharge, subject to an annually adjusted facility-specific limit.

The specific payment method has varied over time. From 1983 to 1998 and again in 2003 and 2004, each provider was paid an operating amount for each discharge, equal to the lesser of its current operating costs or a facility-specific target amount. The facility-specific target amount for each provider was based on its operating costs per discharge during its base year, updated for inflation using a TEFRA market basket index, which measures changes in the prices of goods and services that specialty facilities must buy to produce inpatient care.

The BBA established payment limitations for new IPFs on or after October 1, 1997. These limits reflect 110 percent of the national median target amounts for each group of facilities, updated for inflation. For fiscal year 2005, the limit for psychiatric facilities is $10,529.37. This rate is adjusted to account for differences in input prices among markets.

A facility with costs above its target is paid a relief payment of 50 percent of the costs above 110 percent of the target, up to a maximum of 10 percent of its target.

Operating payments are updated according to a TEFRA market basket. The market basket index for FY 2005 is 3.3 percent.

As is the case for stays in short-term acute care hospitals, beneficiaries treated in IPFs are responsible for a deductible—$876 in 2004—for the first admission during a spell of illness, and for a copayment—$219 per day—for the 61st through 90th days.

[1] Beneficiaries are also treated for psychiatric or alcohol and drug-related conditions in regular beds in acute care hospitals; in these instances providers are paid under the acute care inpatient prospective payment system (PPS).

Beneficiaries treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness, with a 60-day lifetime reserve.[2] Over their lifetimes, however, beneficiaries are limited to 190 days of treatment in freestanding psychiatric hospitals.

Summary of the proposed IPF PPS

The Balanced Budget Refinement Act of 1999 (BBRA) required the Centers for Medicare & Medicaid Services (CMS) to develop a per diem PPS for IPFs with an adequate classification system that reflects differences in patient resource use. The proposed payment system will adjust per diem payments by:

- patient characteristics, such as age, diagnosis related group (DRG), and 17 specified comorbidity categories,
- facility characteristics—the IPF's wage index will be applied to the labor-related share (73 percent) of the per diem payment. IPFs in rural areas will have a 16 percent increase and teaching hospitals will have an adjustment based on the ratio of interns and residents to average daily census, and
- the base per diem payment ($530) will be increased for the earlier days of each patient's stay to account for the higher costs of caring for patients during those earlier days. This method is called "declining block pricing" and creates rate blocks:
  - the payment rate for the first day will be 26 percent higher than the base rate,
  - for days 2 through 4 the rate will be 12 percent higher,
  - for days 5 through 8 the rate will be 5 percent higher.

The IPF PPS will have an outlier policy for cases that have extraordinarily high costs, drawn from an outlier pool of 2 percent. IPFs will be reimbursed for costs above a threshold ($4,200 adjusted for wage index, rural location, and teaching) plus the payment for the case. Medicare will cover 80 percent of the costs for days 1 through 8, and 60 percent of the costs for the remaining days. CMS maintains that different risk-sharing rates are to counteract the financial incentives to keep outlier cases longer than necessary.

Patients who are readmitted to the IPF within 5 days of discharge will be considered as having an interrupted stay and the IPF will be paid for one admission.

CMS estimated that the new IPF PPS will begin on or after April 1, 2004, however the date of implementation has been delayed. IPFs will be subject to the PPS according to their cost reporting year and will transition into the PPS over three years period to 100 percent PPS rates in the fourth year. IPFs will not have the option to be paid at 100 percent PPS rates before the transition is complete because CMS estimates that the number of IPFs opting for 100 percent would, under budget neutrality, reduce the base rate too much. Payments under the new PPS will be budget neutral with what IPFs would have been paid under the previous payment system.

CMS proposes to update the IPF payment rates annually according to the exempt market basket plus capital. The agency estimates that the proposed IPF PPS will redistribute $78 million, or about 3 percent of estimated payments.

[2]Beneficiaries are liable for a higher copayment for each lifetime reserve day—$438 per day in 2004.

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Washington, DC 20001
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Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

Rehabilitation facilities (inpatient) payment system

After an illness, injury, or surgical care, some patients need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. Relatively few beneficiaries use intensive rehabilitation therapy because they must be able to tolerate and benefit from three hours of therapy per day to be eligible for treatment in an inpatient rehabilitation setting. Among those who qualify, many are admitted to inpatient rehabilitation facilities (IRFs), which may be freestanding hospitals or specialized, hospital-based units. Others may receive care in a skilled nursing facility (SNF), especially in markets that lack IRFs or have few rehabilitation beds. Although payments to IRFs (an estimated $5 billion in 2003) represent only a small part of total Medicare spending (about 1 percent), Medicare accounts for a large share of IRF revenues.

Until January 1, 2002, Medicare paid IRFs (under the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA) on the basis of their incurred average costs per-discharge, subject to annually adjusted facility-specific limits. Beginning in January 2002, IRFs are paid predetermined per-discharge rates based primarily on the patient's condition (diagnoses, functional and cognitive statuses, and age) and market conditions in the facility's location. Discharges are assigned to case-mix categories containing patients with similar clinical problems that are expected to require similar amounts of resources. Each case-mix category has a national relative weight reflecting the expected relative costliness of treatment for a patient in that category compared with that for the average Medicare inpatient rehabilitation patient. The payment rates for case-mix categories in each local market are determined by adjusting a national average base payment amount to reflect the input-price level in the local market, and then multiplying the adjusted local amount by the relative weight for each case-mix group. Payment rates also are increased for facilities located in rural areas and those that treat a disproportionate share of low-income patients.

Defining the inpatient rehabilitation products Medicare buys

Under the inpatient rehabilitation prospective payment system (PPS), Medicare sets payment rates for 385 intensive rehabilitation products—called case-mix groups (CMGs)—defined by types of treatment episodes. Patients are assigned to 380 of these treatment categories based on the primary reason for intensive rehabilitation care (for example, a stroke or burn); their age and levels of functional and cognitive impairments; and the types of comorbidities (co-existing conditions) present during the stay. The other five categories are for patients discharged before the fourth day—short-stay outliers—and for those few who die in a facility. Further, IRFs may receive only partial payment for other patients who do not receive a full course of intensive therapy because they are discharged to another facility

and the length of stay is less than that typically provided to patients with the same condition.

Setting the payment rates

The PPS payment rates are intended to cover all operating and capital costs that efficient facilities would be expected to incur in furnishing covered rehabilitation services. The initial payment level (base rate) for a typical discharge—$12,525 for fiscal year 2004—is intended to reflect the projected amount providers would have been expected to receive per discharge under the previous payment system (TEFRA) in 2004. Because providers will receive additional payments under the PPS for extraordinarily costly patients (high-cost outliers), the projected amount is reduced (3 percent) to maintain the same expected total spending.

The base rate is adjusted to account for differences in input prices among markets. The labor-related portion of the base payment amount—72 percent—is multiplied by a version of the hospital wage index and the result is added to the nonlabor portion. The adjusted rate for each market is multiplied by the relative weights for all CMGs to create local PPS payment rates.
Payment rates are increased for IRFs located in rural markets and for those that treat low-income patients. Rural facilities' payment rates are increased by 19 percent to compensate for their tendencies to have fewer cases, longer lengths of stay, and higher average costs per case. An IRF is eligible to receive higher payment rates if it serves at least one low-income patient. The payment adjustment for each facility is based on its low-income patient share, which is the sum of two proportions: the proportion of total inpatient days furnished to beneficiaries eligible for Supplemental Security Income benefits and the proportion of total patient days furnished to Medicaid patients.

Finally, IRFs receive additional payments for high-cost outliers when their costs exceed a fixed-loss threshold. An IRF has a threshold for each CMG equal to its regular payment rate plus a national fixed-loss amount ($11,211) adjusted by the wage index for the IRF's market. For high-cost outliers, IRFs receive their regular payment rates plus 80 percent of their costs above the fixed-loss threshold.

Both the base rate and relative weights are updated annually. The base rate is updated using the TEFRA market basket index (used for facilities originally excluded from the acute care hospital PPS) expanded to reflect changes in the price of capital. The relative weights are updated based on changes in national average charges per discharge for each CMG.

The Centers for Medicare & Medicaid Services (CMS) recently issued a final rule making several changes to criteria defining IRFs. For cost reporting periods beginning on or after July 1, 2004, the rule expands, from 10 to 13, the number of qualifying medical conditions used to classify a facility as an IRF. The thirteen conditions are:

- stroke
- spinal cord injury
- congenital deformity
- amputation
- major multiple trauma
- hip fracture
- brain injury
- neurological disorders (e.g., multiple Sclerosis, Parkinson's)
- burns
- three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed
- joint replacement when bilateral knees or hips when the surgery immediately precedes admission, body mass index $\geq$50, or age 85+.

Additionally, in order to receive payment as an IRF, a certain percentage of a facility's total patient population must have one of the qualifying medical conditions. Previously, this "compliance threshold" was set at 75 percent; however, the final rule temporarily lowers the threshold for the next three years:

- For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the compliance threshold is set at 50 percent of the IRF's total patient population;

- For cost reporting periods beginning on or after July 1, 2005, and before July 1, 2006, the compliance threshold is set at 60 percent of the IRF's total patient population; and

- For cost reporting periods beginning on or after July 1, 2006, and before July 1, 2007, the compliance threshold is set at 65 percent of the IRF's total patient population.

During this three-year period, CMS will monitor the impact of the revised criteria, including patients' access to care, and promote research to identify patients and medical conditions that most need intense rehabilitation services as provided by IRFs. On July 1, 2007, the compliance threshold will return to 75 percent. The rule also:

- Establishes an administrative presumption that if a facility's Medicare population meets the compliance threshold, the facility's total population does as well;

- Counts, in addition to principal diagnoses, secondary medical conditions that meet one of the 13 medical conditions that qualify towards the compliance threshold for IRFs. The secondary condition, even in the absence of the admitting condition, must cause a significant enough decline in the patient's functioning that the individual would need intensive rehabilitation services best provided in an IRF; and

- Changes the period of time to review patient data to determine compliance with the percentage threshold from the most recent 12-month cost reporting period to the most recent, appropriate and consecutive 12-month cost reporting period.

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Washington, DC 20001
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Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

Skilled nursing facility services payment system

Beneficiaries who need short-term skilled care (nursing or rehabilitation services) on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in skilled nursing facilities (SNFs). SNFs can be hospital-based units or freestanding facilities, with 90 percent of all SNFs located in freestanding facilities. About 1.4 million beneficiaries use SNF care in a year, but Medicare's payments for these services account for only about 12 percent of freestanding nursing facilities' revenues (25 percent of revenues in many large for-profit nursing home chains); they make up less than 2 percent of hospitals' revenues. Similarly, payments to SNFs (about $17.3 billion in 2004) represent only about 5.2 percent of total Medicare spending.

With approval from CMS, certain Medicare-certified hospitals (typically small, rural hospitals and critical access hospitals) may also provide skilled nursing services in the same hospital beds they use to provide acute care services. These are called swing bed hospitals.

Medicare adopted a new prospective payment system (PPS) for SNF services starting on July 1, 1998. Prior to that, SNFs were paid on the basis of their costs, subject to limits on their per diem routine costs (room, board, and routine nursing care); no limits were applied for ancillary services (such as drugs and therapy). Under the PPS, SNFs are paid a predetermined rate for each day of care. The per diem rates are based primarily on the patient's expected service needs and market conditions in the facility's location.

The product that Medicare buys

Patients are assigned to one of 44 resource utilization groups, version III (RUG-III), each containing patients with similar service needs that are expected to require similar amounts of resources. Patients' expected service needs are determined by periodic assessments of their condition, including their needs for intensive physical, occupational, or speech therapy; special treatments (such as tube feeding); and their functional status (their ability to manage unassisted ordinary daily activities, such as eating, bathing, and dressing).

Setting the payment rates

The PPS rates are expected to cover all operating and capital costs that efficient facilities would be expected to incur in furnishing covered SNF services (with the exception of certain high-cost, low-probability ancillary services). The daily rate for each of the 44 RUG-III groups is the sum of three components:

- a fixed amount for routine services (such as room and board, linens, and administrative services);

- a variable amount reflecting the intensity of nursing care patients are expected to require; and
- a variable amount for the expected intensity of therapy services.

The rates are computed separately for urban and rural areas, and the rates are adjusted to account for differences in input prices among SNF markets. The labor-related portion of the daily payment rate—slightly over 76 percent for fiscal year 2004—is multiplied by the hospital wage index in the SNF's location and the result is added to the nonlabor portion. Rates are updated annually, based on the projected increase in the SNF market basket index, a measure of the national average price level for the goods and services SNFs purchase to provide care.

The initial payment rates in 1998 were set to reflect the projected amount that SNFs received in 1995, updated for inflation.[1] Because of some perceived problems with the initial SNF payment rates, the Congress temporarily increased the rates in several ways:

- the Balanced Budget Refinement Act of 1999 (BBRA) increased rates for all 44 RUG-III groups by 4 percent for care furnished from April 2000 through September 2002,
- the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) increased the base rate for the nursing component by 16.66 percent for care furnished from April 2001 through September 2002,
- the BBRA and BIPA increased rates for 14 rehabilitation groups by 6.7 percent, and those for 12 complex care groups by 20 percent. These increases were intended to give CMS time to refine the RUG-III classification system, and they expire when CMS adopts that refinement, and
- the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 increased the per diem RUG payment for a SNF resident with AIDS by 128 percent for services furnished on or after October 1, 2004. However, SNFs will not receive the 6.7 percent increase for 14 rehabilitation groups and the 20 percent increase for 12 complex care groups mandated by the BBRA and BIPA, if applicable, for a resident with AIDS.

The first of these temporary payment increases expired on October 1, 2002.

[1] By law, this projection excluded costs of SNFs that were exempt from Medicare's routine cost limits or that had so-called atypical exceptions in 1995 and included only 50 percent of the difference between the average costs of hospital-based and freestanding facilities.